Sunrise Psychiatry, LLC
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INFORMED CONSENT FOR TREATMENT

Patient Name: _____ DATE: _____

Our goal is to provide the best possible treatment for our patients. We strive to create a safe, therapeutic environment that promotes healing, and growth in your daily lives. The purpose of this document is to explain policies and responsibilities surrounding treatment so that you may give well informed consent for the psychiatric and mental health services offered at Sunrise Psychiatry, LLC. Please initial each item listed below if applicable.

INFORMED CONSENT FOR TREATMENT:

_____ I agree to disclose all pertinent information regarding my past and current symptoms, medications (including OTC and street drugs), medical history, and family history so that my provider can effectively diagnose and formulate a treatment plan tailored to my specific needs.

_____ I understand that this treatment plan will be explained to me and I am free to ask any questions about my treatment during my appointments. I understand that my provider will educate me about risks and benefits of prescribed medications, including potential side effects. I agree to comply with this treatment plan and understand that I can withdraw from treatment at any time.

TREATMENT/MEDICATION POLICIES:

_____ I agree to take the medications prescribed to me the way they are written. I agree not to alter my medication without prior instruction from a medical provider at Sunrise Psychiatry, LLC. I agree not share, dispense, or sell any of the medications prescribed to me. Doing so will result in termination of treatment at Sunrise Psychiatry, LLC.

_____ My Provider will regularly check the government database of controlled Substance medications dispensed, as required by law. I understand that my provider may also randomly request lab work to be completed in an effort to determine the best course of action for my treatment or medication tolerance.

_____ I understand that some medications may have addictive properties. My provider will act in my best interest to minimize and protect me from this risk. This includes their right to discontinue prescribing these medications if they believe the risk to my health and safety outweighs the benefit. This discontinuation may be with or without 30 day notice, depending on the circumstances.

_____ I understand that all Schedule II medications, as required by law, require a paper prescription to be completed by our medical provider(s) during a face-to-face evaluation and that this paper must be hand-delivered to the pharmacy by the actual patient and/or legal guardian (legal ID is also required by Pharmacy Guidelines).

_____ I understand that State and Federal Guidelines, as well as those mandated by our Insurance Company Contracts and Internal Regulatory Systems, require a face-to-face or Telehealth/Telemedicine appointment with our medical providers prior to prescribing medications and/or medication refills. **No prescriptions or Refills** are provided without a scheduled appointment with my provider. Additionally, early refills of controlled substances may not be authorized and should not be expected. This policy applies to both existing and new patients. This policy ensures not only compliance with guidelines and regulatory agencies, but also ensures best practices and advocates for patient safety and well-being.

TELEHEALTH / TELEMEDICINE:

_____ I understand that my provider may suggest/request for me to engage in a telehealth / telemedicine appointment.

_____ Similar to an office visit, in a telehealth / telemedicine appointment, I have been given the opportunity to ask my provider questions in regard to this appointment. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language that I understand.

_____ I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of my provider, that: the transmission of my medical or mental health information could be disrupted or distorted by technical failures; the transmission of my medical or mental health information could be interrupted by unauthorized persons; the electronic storage of my medical information could be accessed by unauthorized persons; and/or limited liability to respond to any medication questions/concerns or emergencies.

_____ I understand that telehealth / telemedicine based services and care may alter the effectiveness of treatment due to the fact that I will not be in the same room as my provider. As such, I understand that my provider may not continue to provide such telehealth / telemedicine appointments if they recommend otherwise in the future.

SCOPE OF PRACTICE:

_____ I understand that in an effort to meet the needs of our patients as well as cover the costs for our administrative staff and our provider's time, we require a nominal fee for the following tasks/items: copies of medical records and/or letters written from our providers about treatment, diagnosis or medications.

_____ Please note that as a general rule, we do NOT provide input regarding an individual's ability or inability to perform their work/school functions. Therefore, we do NOT write letters or complete forms for things such as, but not limited to, disability, FMLA, excuse from work or school (aside from confirmation of date and time that you were seen at the office for a scheduled appointment), and educational/testing accommodations. We also do NOT complete letters or forms for emotional support animals.

_____ I have read, reviewed, understand and have signed the "Patient Rights, Confidentiality and HIPAA" form.

_____ I have read, reviewed, understand and have signed the "Authorization for Release of Information" form

_____ I have read, reviewed, understand and have signed the "Patient Financial Responsibilities" form, including the Missed Appointment/Late Cancellation policy and fees associated.

ACADEMIC/STUDENT INVOLVEMENT:

_____ I understand that my provider may have students present in their sessions as they are participating with local colleges/universities as preceptors to teaching in a field study setting. I am free to decline student involvement and this will not adversely impact my treatment in any way. The provider will also always be present during this time.

Please indicate here if you are okay with having a student present during your sessions. ☐ Yes ☐ No

I agree and consent to participate in the psychiatric and mental health services offered at Sunrise Psychiatry, LLC. I understand that I am consenting and agreeing only to the specific services provided in the scope of practice and the scope of the provider's license, certification, and training including a psychiatric diagnostic evaluation and individualized treatment plan which includes medication management, psychotherapy, and patient education. Additionally, my treatment may include collaboration with other providers and pharmacogenomic testing if/when necessary or recommended by my provider.

By signing this form, I am acknowledging prior to receiving treatment at Sunrise Psychiatry, LLC that I have received, read and understand this informed consent and have asked the front office staff or my provider to explain any portion of it that I do not understand.

_____ _____

Signature of Patient/Guardian/Representative Date

_____ _____

Signature of Staff Member at Sunrise Psychiatry, LL Date